

~OFFICE USE ONLY~

DATE _____

APPROVED _____

EXPIRES _____

- ☐ BACKGROUND CHECK
☐ ID CARD
☐ CERTIFICATE
☐ EIC—CERTSCAN
☐ DOCUWARE
☐ REGULATORY_____

ARKANSAS DEPARTMENT OF HEALTH
SECTION OF EMERGENCY MEDICAL SERVICES
5800 W. 10TH STREET SUITE 800
LITTLE ROCK AR 72204-1763

EMSP Licensure Tracking Sheet
PRINT IN INK OR TYPE

--OFFICE USE ONLY--

Customer # _____

Payment Type: _____

Amount Received: _____

EMT NUMBER _____

CHECK LEVEL(S)

- ☐ EMT
☐ ADVANCED EMT
☐ PARAMEDIC
☐ EMSP INSTRUCTOR
☐ RECIPROCITY
☐ INITIAL LICENSURE
☐ LICENSURE RENEWAL

Current Expiration Date

Initial Licensure Date

NAME _____
Last First MI

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

COUNTY _____ HOME and/or WORK PHONE _____

EMAIL ADDRESS _____

BIRTH DATE _____ AGE _____ MALE _____ FEMALE _____

SOC SEC# _____ DRIVER'S LICENSE# _____ STATE _____
(Photo ID must be presented at State exam)

EMERGENCY MEDICAL SERVICES PROVIDER – MEDICAL TRAINING
(ONLY WHAT APPLIES TO THIS LICENSURE PERIOD)
ATTACH DOCUMENTATION

COURSE TITLE	COURSE #	NUMBER OF HOURS Class/Clinical/Field	END OF COURSE DATE	PLACE (City)	INSTRUCTOR
EMT					
ADVANCED EMT					
PARAMEDIC					
INSTRUCTOR					